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Editor's Corner: DSM-5—Ready or Not, Here It Comes

IN JULY 2012, the *Journal of Studies on Alcohol and Drugs* (JSAD) printed an exchange of ideas among Griffith Edwards (2012) in the United Kingdom and three members of the Substance Use Disorders Work Group of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association, 2013): Debra Hasin (2012), Charles O'Brien (2012), and me (Schuckit, 2012). In the ensuing year, the DSM-5 committee received additional input and discussed the final format for the Substance-Related Disorders section, and the DSM-5 process drew to a close. The manual was released for general use in May 2013.

This editorial follows up on that earlier correspondence to offer thoughts on the changes clinicians will see in the new DSM. It is important to note that the ideas I express here are my own and do not necessarily reflect the views of JSAD or other members of the DSM-5 Substance-Related Disorders Work Group. The good news is that the section on the substance-related disorders has few (if any) major changes, and the alterations that were made should be fairly easy to implement. However, before listing what you see in the new manual, I'd like to offer a bit of background.

As I see it, the DSMs offer guidelines for clinicians dealing with patients who have problems with any of nine different classes of drugs. To be useful for the busy clinician, the criteria must be straightforward and flexible enough to be relevant to all nine drugs, older and younger individuals, men and women, and people from a range of cultural backgrounds. Therefore, almost by definition, the DSM is not a research manual. Researchers will need to consider the new criteria in light of complex interrelationships among genetic, environmental, developmental, and other forces that contribute to psychiatric conditions. They also need to "operationalize" and standardize the criteria by creating questions to evaluate each criterion item. I hope that, in the future, the national alcohol and drug institutes will consider developing standard wording for asking about each criterion item both for self-administered questionnaires and for interviews and make them available to both researchers and clinicians for their consideration. This would increase the chance that we are all referring to the same issues when we screen for substance-related conditions. However, this step, as important and useful as it may be, is not the goal of the DSM itself.

The philosophy of the DSM-5 Substance-Related Disorders Work Group was that changes from DSM-IV (American Psychiatric Association, 1994) to DSM-5 needed to be carefully evaluated. Any alteration could affect the relevance to future clinical work and research for the huge number of advances in knowledge that have accrued regarding DSM-III-R in 1987 and DSM-IV in 1994 (the criteria for those two editions are quite similar). Therefore, changes to the diagnostic system needed to be supported by adequate data. A recent article by Hasin et al. (in press) and a letter to the editor (Hasin et al., 2013) describe the approaches used to evaluate data from more than 200,000 individuals that were available to the DSM-5 Work Group as we considered the assets and liabilities of possible alterations for DSM-5.

Finally, in this brief introduction, the Work Group compared the prevalence of persons diagnosed using DSM-5 substance use disorders criteria with the prevalence of alcohol and other drug abuse and dependence using DSM-IV. As noted by Hasin et al. (in press), the prevalence rates across the two systems are quite similar.

With that background, I turn to what I see as some of the most notable changes in DSM-5 and offer some thoughts about what needs to be done to prepare for future iterations of the diagnostic manual. To me, the major changes for substance use disorders in DSM-5 include the following:

1. DSM-5 criteria for substance use disorders are less complicated than DSM-IV's and are easier for the clinician to use. In DSM-IV, one needed to first screen to see if three of seven dependence items clustered together in about the same year. If not, the clinician then needed to screen for clustering of four additional items to justify the diagnosis of abuse (in the absence of dependence). In the DSM-5 approach, 11 items are listed, and an individual is diagnosed with a substance use disorder if two or more criteria are endorsed for the same 12-month period. Thus, DSM-5 uses a one-step process compared with the two steps required in DSM-IV. Using a single criteria list also decreases the chance that someone will fall through the cracks between abuse and dependence (e.g., diagnostic orphans who met one or two dependence criteria but none for abuse and who, therefore, could not be diagnosed with either condition).

2. Although DSM-IV offered guidelines of how to determine severity, these were rarely used in clinical settings. In contrast, DSM-5 offers clear and easy to implement rules

for mild, moderate, and severe substance use disorders, three categories that were mandated for every DSM-5 section. It is important to note that even the mild substance use disorder (two or three criteria endorsed) can only be diagnosed in the context of significant impairment in life functioning or distress to the individual or those around them. Thus, this label indicates that an individual very likely needs treatment. The moderate (endorsement of three or four items) and severe (five or more items) categories indicate more severe conditions, but the distinction between impaired and not impaired rests with two or more items endorsed. A recent article by Compton et al. (2013) indicates that a mild substance use disorder has similarities to abuse in DSM-IV, whereas moderate and severe conditions have parallels to dependence. The diagnostic numbering system for DSM-5 still uses the *International Classification of Diseases, Ninth Revision* (ICD-9; World Health Organization, 1977), as was the case for DSM-IV.

3. Modest progress was made to further simplify the diagnostic system by trying to delete items that were redundant or rarely endorsed. As reviewed in the Hasin et al. (in press) article, the DSM-IV abuse item regarding legal problems was rarely endorsed and, if noted, was usually seen in the presence of additional diagnostic items; therefore, it was rarely an essential criterion for fulfilling the diagnosis. Thus, the criterion regarding legal problems was deleted for DSM-5. At the same time, the Work Group was split on the importance of adding a criterion item for craving, with the majority feeling that craving added enough information to the criteria set regarding several of the drugs to be worth incorporating. Finally, several other potential redundancies among criterion items were observed, including the use of two separate criteria dealing with continuation of use of a substance despite psychosocial problems and despite physical or psychiatric problems. Similarly, there is potential overlap between two items relating to giving up important social, occupational, or recreational activities because of substance use and substance use resulting in failure to fulfill major role obligations at work, school, or home. However, these issues arose late in the DSM-5 process at a time when several new oversight committees were requesting additional documentation of the other changes that the Work Group had proposed. As a result, there was insufficient time left to carry out a full set of analyses regarding whether these four criterion items could be reduced to two. Prior evaluations by the Work Group did not clearly support removing these potentially redundant items from the list, and, in the absence of more definitive data, the full set of criteria remained at 11.

4. The importance of substance-induced psychiatric syndromes originally amplified in DSM-IV was maintained and expanded in DSM-5. Substance-induced depressions, psychotic episodes, anxiety conditions, and so on had been noted in one form or another since DSM-III (American Psychiatric Association, 1980). DSM-IV in 1994 took steps to highlight these conditions that resemble independent psychiatric disorders (e.g., major depressive episodes) but, unlike the independent syndromes, are likely to improve and disappear within a month of abstinence. The 1994 manual moved substance-induced intoxication, withdrawal, and substance-induced psychiatric conditions from what was known as the "organic" disorders into the DSM-IV substance-related chapter and also listed these conditions in each relevant psychiatric chapter (e.g., mood, anxiety, and psychosis disorders sections). That step paralleled how clinicians were likely to use DSM by looking through sections that might relate to the diagnosis being considered. In DSM-5, a similar approach is used, as the Substance-Related Disorders Work Group interacted closely with work groups for the other diagnostic issues (e.g., neurocognitive disorders, anxiety conditions, and mood disorders). There was equal input from experts in both committees as we compromised regarding the conditions to be listed, including the addition of substance-induced bipolar and obsessive–compulsive syndromes.

5. Gambling disorder, listed with the impulse disorders in DSM-IV, was moved to the same section as the substance-related disorders in DSM-5. To me, this was justified by the fact that gambling disorder (previously known as pathological gambling) did not fit with the impulse disorders, because many problematic gamblers are not generally impulsive. Nor would it have been appropriate to place gambling syndromes with the mood conditions or the anxiety disorders, even though symptoms of those conditions are often seen in the context of gambling problems. At the same time, gambling disorder is a relatively prevalent, serious, and well-documented condition that needed to be listed somewhere within the manual, and, as a behavioral condition focusing on repetitive problems despite consequences, it was better suited to be listed with the substance use disorders section than anywhere else. However, placing it with the substance use disorders *did not imply that we know that gambling disorder is just a variation of a substance use disorder*. In fact, when an effort was made to replace the DSM-IV gambling criteria with the criteria set for substance use disorders, the gambling condition did not fit appropriately into the substance use disorder framework, and it was decided to continue to use the gambling disorder criteria from DSM-IV (with slight modifications).

Consistent with our worry that gambling and substance use conditions might not represent a unitary phenomenon, the Work Group voted to name our chapter "Substance-Related Disorders and Gambling Disorder." However, members of a DSM-5 oversight committee disagreed and, against our advice, unilaterally changed the name of the chapter in DSM-5 to what finally became "Substance-Related and Addictive Disorders." Our committee appealed that decision, but to no avail.

Currently, I believe that no other repetitive behavioral condition has sufficient data to justify adding new diagnoses

related to excessive Internet use; excessive Internet gaming; or excessive exercise, shopping, sex, and eating. My view is that until: (a) any such disorders have been reliably defined; (b) the clinical implications and clinical course have been clearly established; (c) data have accrued to demonstrate that the new condition is not a variant of an already well-established diagnosis; and (d) data regarding life impairment and/or significant distress have been published, no such diagnoses should be added into a manual. Even if these four criteria for a threshold are reached, careful thought must be given to whether such potential "behavioral addictions" are similar enough in etiology, course, and treatment to be listed with the substance use disorders, or if it is best to place them in a new section of their own.

In closing, clinicians face relatively few challenges in adjusting from DSM-IV to DSM-5 substance use disorders. The major changes were clearly supported by data that demonstrated more assets than liabilities to the new approach. At the same time, it is not too early to begin to think about future iterations of DSM-5 and for DSM-6. Issues may include evaluating whether additional items can be deleted from the criteria set and gathering appropriate data regarding the possible importance of repetitive harmful behaviors. Another issue relates to potential criteria for a Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (i.e., a fetal alcohol syndrome–like condition), which deserves future consideration and testing.

These comments are just one person's opinion. I invite people who have alternative views to write letters to the editor of JSAD, and I hope that a lively discussion develops.

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